APPLICATION FOR LONG-TERM CARE SERVICES - MENTAL HEALTH HOSPITAL / SED WAIVER

State Form 51550 (3-04) / TS 0001

The information contained on this completed form is **CONFIDENTIAL** according to IC 16-39-2.

Application is for (*check one*)

☐ Mental Health Hospital ☐ SED Waiver

Name of applicant	Telephone number ( )
Home address (*number and street, apartment number, city, state, ZIP code*)	
Date of birth	Sex ☐ Male ☐ Female
Age	

MEDICAID STATUS (*check all that apply*)

State

☐ Medicaid applicant county

☐ Medicaid recipient number

☐ Will apply for Medicaid immediately — Application date (*month, day, year*)

☐ Medicaid Waiver services recipient

☐ Medicaid MCO Enrollee — ☐ Medicaid effective date

Referral source: ☐ Other:_____

☐ State Hospital ☐ Community Mental Health Center ☐ Dept. of Education ☐ Dept. of Correction

Applicant's location at time of application

☐ Home

☐ Mental Health Hospital ☐ In-state

☐ Acute Care Hospital ☐ In-state

☐ Nursing Facility

☐ CMHC

☐ Other
Address: _____

Name of parent / guardian	Telephone number ( )
Address (*number and street, city, state, ZIP code*)	

☐ I agree to participate in the mental health hospital screening to determine the need for hospital care and / or waiver services at home and in the community.

☐ I authorize the release of information to and among state agencies and their agents on my child's medical condition, and other relevant information necessary to determine appropriate long-term care services and / or in-home services by my physician, hospital, nursing facility, Community Mental Health Center, The Division of Mental Health and Addiction, the Office of Family and Children, other social service or health services providers, and family members. I understand I may revoke this release of information in writing at any time.

Signature of applicant / parent / guardian / responsible person	Date (*month, day, year*)	Time ☐ AM ☐ PM
If signature of responsible person, what is the relationship to the applicant?		
Signature of witness (*required if the signature is an "X"*)		
Signature of Community Mental Health Center or State Hospital Designee	Date (*month, day, year*)	

Name(s) and address(es) of State Hospital(s)

1.

2.

3.

4.

5.

6.

DISTRIBUTION: ☐ Original CMHC ☐ Applicant ☐ State Hospital File ☐ DMHA ☐ OMPP